Mid-Valley Hospital **Policy and Procedure**	**No:8530.0015.2000.01**
Subject: **Charity Care** **(Community Assistance Program)**	**Page: 1 of 4** **Draft Date: 11/27/2000** **Revised Date: 1/2/2007**

POLICY:

This facility is committed to serve without exclusion and to provide appropriate hospital-based medical services to all persons in need of medical attention, regardless of ability to pay. Charges that exceed a patient's ability to pay and which are not covered by any third party payment sources, including Medicare and Medicaid, shall be considered eligible for application to the charity care program.
In order to protect the integrity of the operations and fulfill this commitment, the following criteria for the provisions of charity care have been established. These criteria will assist the staff in making consistent and objective decisions regarding eligibility for charity care, while ensuring the maintenance of a sound financial base.

SCOPE: Business Office Manager, Chief Financial Officer and Administrator

RESPONSIBILITIES: Business Office Manager, Chief Financial Officer and Administrator

CONTROL: Business Office Manager, Chief Financial Officer and Administrator

A. DEFINITIONS

"Appropriate hospital-based medical services" means those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life or cause suffering or pain or result in illness or infirmity or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For purpose of this section, "course of treatment" may include mere observation or, where appropriate no treatment at all. (WAC 246-453-010).

"Indigent persons" means those patients who have exhausted any third party sources, including Medicare and Medicaid, and whose income is equal to or below 200% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third party payor. (WAC 246-453-010).

"Income" means total cash receipts before taxes derived from wages and salaries, welfare, payments, social security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual (WAC 246-453-010).

Charity care recipients would be allowed to retain the same nonexempt resources they would retain under the Medicaid program.

"Partial charity" for a portion of expenses can be available under appropriate circumstances, even if qualification for total charity care does not exist. In addition, Medicaid liabilities or share of cost and Medicare deductibles may be considered for charity eligibility.

B. ELIGIBILITY CRITERIA

1. Charity care is always secondary to any other financial resources available to the patient including and government subsidized program, third party liability carriers or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical service.
2. In those situations where appropriate primary payment sources are not available, patients may be considered for charity care based on the following:

   a. All responsible parties with family income equal to or below one hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship. (WAC 246-453-040[1]).
   b. All responsible parties with family income between one hundred one and three hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for discounts from charges related to appropriate hospital based medical services in accordance with the hospital's sliding fee schedule and policies regarding individual financial circumstances. (WAC 246-453–040[2]).
   c. Available assets may be used to determine eligibility for charity care if the family's income is less than 300% of the federal poverty guidelines.
   d. The hospital may also assign charity care in those instances when families with income in excess of 300% of the federal poverty guidelines are in circumstances which indicate severe personal hardship or personal loss, e.g. death of primary wage earner or extreme, catastrophic medical services.
   e. Financial screening to rule out potential eligibility for Medicare or Medicaid benefits or third party liability benefits will be done prior to processing charity applications.

PROCEDURE:

A. IDENTIFICATION OF A POTENTIAL CHARITY CARE RECIPIENTS AT TIME OF ADMISSION

Responsibility: Admitting Staff

1. At time of admission or registration, admitting staff will determine the patient's responsibility to pay if the patient is uninsured. A brief screening will be conducted in the course of the registration process. If the patient is unemployed, the staff will determine how the patient plans to pay for the services, e.g., at time of service, when billed, through payment plans or unable to, etc.
2. The admitting staff will provide patients with the appropriate Payment Plan Applications or a Charity Care Application (CAP) dependant on the results of the financial screening.
3. All payment plans and CAPs will be forwarded to the financial Counselor on a daily basis.
4. In the event that a patient is unable or has not been screened during the course of the admission, the financial counselor is expected to review all potential uncompensated accounts and conduct a financial screening with the guarantor and initiate CAP application when appropriate.

B. PROCESSING CAP APPLICATIONS

Responsibility: Financial Counselor

1. Upon receipt of the CAP application income, the Financial Counselor will verify expenses and/or the lack of resources. The guarantor will be asked to provide verification of income and to bring copies of the following documents when available. Not all of the documents are required, only those that are appropriate and will support a decision for CAP. Income or ability to pay information may be documented from one or more of the following:
   a. Payroll check stubs or W2 withholding statements
   b. Bank statements for the last six months
   c. Income tax returns for recent year
   d. Medicaid denial
   e. SSI denial
   f. Unemployment benefits denials or pay stubs
   g. Rent receipts
   h. Dependent birth certificates

   Collectively, the above documents will support a financial picture that will allow Mid-Valley Hospital to make consistent decisions when authorizing charity care accounts.

2. Information requests for the verification of income and family size shall be limited to that which is reasonably necessary and readily available to substantiate the guarantor's qualifications and will not be used to discourage applications for charity care programming.

3. The Financial Counselor, with assistance from Social Services, will conduct a financial screening to determine if the patient is potentially eligible for State or Federal funding, example, Medicaid or SSI Medicare. If their medical history or personal status indicates potential benefits, the guarantor will be asked to apply for this funding before processing CAP applications.

4. The guarantor will be asked to provide income verification documents within fourteen days from the date of meeting. The failure of a responsible party to reasonably complete the appropriate application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient.

5. The Financial Counselor, upon receipt of all verification documentation, will have fourteen working days to review and recommend approval or disapproval of the applications.

6. The Financial Counselor will forward all applications, with recommendations, to the Business Office Manager for review and to obtain appropriate authorizations.

7. If the account is approved for CAP, the Financial Counselor will change the financial class to "PAM" (Patient Account Management) which will then be presented to the Board for approval, then will write the account off the system with the transaction code that corresponds to CAP in the General Ledger.

8. If the application is denied, the Financial Counselor will notify the patient, in writing, advising guarantor of the reason for the denial and also advising them of the appeal process.

C. IDENTIFICATION OF CHARITY ACCOUNTS DURING PRE-COLLECTIONS ACTIVITY

Responsibility: Patient Account Representative (PAR)

1. The Patient Account Representative (PAR), in the course of pre-collection activity, may identify potential charity accounts. The PAR will send a Notice of Charity Care in the pre-collect letter to the patient's guarantor.

2. Upon receipt of the completed CAP application, follow guidelines as outlined in BI-B8.

D. CHARITY APPROVAL AUTHORITY LEVELS

1. All balances will be tentatively approved on a daily basis by the Business Office Manager.

2. The Board will review and approve all write off's on a semi-monthly basis.

E. APPEAL PROCESS

1. All applications will receive written notice of the approval or denial.

2. Patients/Guarantor may appeal by writing a letter explaining why they feel the denial is inappropriate and or by supplying additional information to support a favorable decision.

3. The patient should be given 30 days to appeal the decision.

4. Appeals should be directed to the Business Office Manager and should be responded to within ten days from date of receipt.

5. The hospital should make every reasonable effort to reach initial and final determinations of charity care designation in a timely manner; however, hospitals shall make those designations at any time upon learning of facts or receiving documentation, as described in WAC 246-453-030, indicating that the responsible party's income is equal to or below two hundred percent of the federal poverty standard as adjusted for family size. The timing of reaching a final determination of charity care status shall have no bearing on the identification of charity care deductions from revenue as distinct from bad debts.

6. In the event that a responsible party pays a portion or all of the charges related to appropriate hospital based medical care services, and is subsequently found to have met the charity care criteria at the time that services were provided, any payments in excess of the amount shall be refunded to the patient within thirty days of achieving the charity care designation. WAC 246-453-040.